ATTACHMENT 5

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STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE – DIVISION OF INVESTIGATIONS
P.O. Box 95164, Lincoln, Nebraska 68509-5164
402-471-0175

DEDODTING BY INCLIDED	
REPORTING BY INSURERS	

PROFESSIO	ONAL I AM REPORTI	NG					
Name:	First:	Middle/MI	Last:		Maider	n:	Date of Birth:
Work	Street:						
Address:	City:		State:				Zip:
Home	Street:						
Address	City:		State:			Zip:	
Telephone	Home:		- 1	Work			
				I			
LIST THE F	TELD AND NUMBER	FOR EACH NEE	BRASKA LICE	NSE, CE	RTIFICATE (	OR REGISTE	RATION HELD
	License Field			Licen	se Number		
Reporting I	Party						
Name:	•						
Title:							
Organization	n:						
Address:							
Telephone I	No.		FAX	No.			
E-mail Addr	ess:		I				
Relationship	to Health Care Profes	ssional:					

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	1. 2.	We have made a payment resulting from a professional liability claim.  We have taken an adverse action that affects the coverage provided by the insurer due to alleged:				
		☐ Incompetence ☐ Negligence				
		☐ Unethical				
		<ul><li>Unprofessional conduct</li><li>Physical, mental or chemical impairment</li></ul>				
		Type of action taken  ☐ Denial of coverage				
		Refusal to renew coverage				
		<ul><li>Coverage terminated or cancelled</li><li>Coverage limited, reduced or modified</li></ul>				
		Premium or rate increase				
		☐ Other				
		Date adverse action was taken:				
		Person is subject to National Practitioner Data Bank requirements and Data Bank				
		Supplement form completed.				
		Person not subject to National Practitioner Data Bank and next page completed.				
	3.	The insurer has reasonable grounds to believe that the practitioner has committed a violation of				
	4.	the regulatory provisions governing the profession or practitioner.  The Department has requested the insurer to provide information.				
Datia						
		Client Date of Birth:				
Name		Date of Birth:				
Addre	ess:					
·						
Loca	tion	of act omission or conduct being reported				
Loca		of act, omission or conduct being reported				
Name	e:	of act, omission or conduct being reported				
	e:	of act, omission or conduct being reported				
Name	e: ess:					
Name	e: ess:	of act, omission or conduct being reported  Occurrence:				
Addre Date	e: ess:	Occurrence:				
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## MALPRACTICE PAYMENT

name of patient or client:					
Address:					
Name of court:					
Address:					
Date of judgement, settlement or award:					
Date of payment:					
Amount of payment:					
Description of the facts surrounding the reason for the	payment for the act or omission:				
Date of occurrence:					
Where did it occur?					
How did the act or omission occur?					
The nature of any injury, illness, damage or other loss upon which the claim was based:					
The flatare of any injury, limess, damage of other loss upon which the claim was based.					
Persons present at time of act or omission or with first hand knowledge:					
Name	Title				
Address	Telephone				
Name	Title				
Address	Telephone				
	Title				
Name					
Address	Telephone				